Oklahoma Dental Surgery Centers Referral Form

PATIENT INFORMATION:

Today's Date ____________________

First Name ____________________ Last Name ____________________ Date of Birth ____________________

Parent/Guardian Name ____________________

Contact Telephone ____________________ Contact E-Mail Address ____________________

Does the patient require antibiotics prior to dental treatment? ❏ Yes ❏ No ❏ Patient will call for appointment ❏ Please call patient

Treatment ____________________

REFERRING DOCTOR'S INFORMATION:

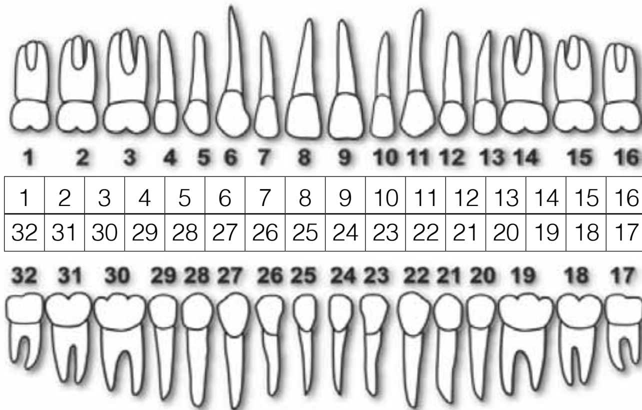
Referred By ____________________ Telephone ____________________

E-Mail Address ____________________

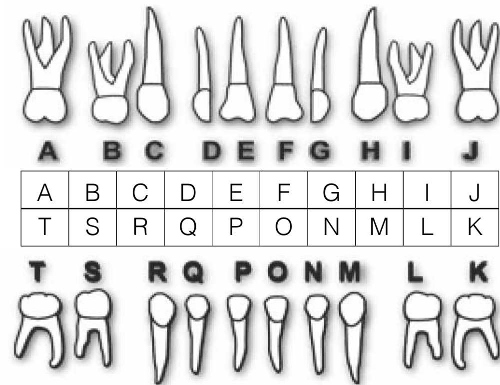
PROCEDURES:

- ❏ Extraction (see below)
- ❏ Alveoplasty
- ❏ Incision & Drainage
- ❏ Implant
- ❏ Sinus lift
- ❏ Exposure
- ❏ Hard Tissue
- ❏ Infection
- ❏ Soft Tissue
- ❏ Bone Graft
- ❏ Frenectomy
- ❏ Other ____________________

____



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17



A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

Please Verify Teeth For Extraction and/or implant placement ____________________

RADIOGRAPHS OR CLINICAL PHOTOS:

- ❏ Please Take
- ❏ No X–Ray
- ❏ Attached with this referral.

If X-Rays are attached, what date were they taken ____________________

INSURANCE INFORMATION:

Insurance Company ____________________ Member ID ____________________

Group # ____________________

CASE NOTES:

Please submit completed form and x-rays to office@okdsc.com or by fax (405) 444-7456

Oklahoma Dental Surgery Centers

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